

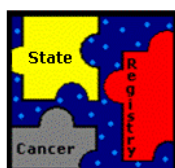


National Program of Cancer Registries

Welcome to Web Plus

Application for Secure Cancer Reporting Over the WWW

Arkansas Central Cancer Registry



Web Plus V3.4.0

Please log in

User ID

Password

There is a new address for Web Plus:

<https://adhcancer.arkansas.gov/WebPlus/logonen.aspx>

Please begin to use this new address and save it to your 'Favorites'

The log in page (screenshot above) is where you will enter your User ID and password as assigned by the WebPlus ACCR Administrators: (Contact)

Arkansas Central Cancer Registry

(501-661-2960)

Web Plus



Web Plus Home Page for Melissa Riddle

Please select a central cancer registry function from those listed below.



Your name will
appear here

Arkansas Central Cancer Registry



Facility Name appears here

[Central Registry Administrator](#)

[Central Abstractor/Reviewer Functions - ACCR 2011 - Full Abstract](#)

[Central Abstractor/Reviewer Functions - ACCR 2011 - Full Abstract](#)



Roles assigned to you

After logging into the system this page will appear with your facility name and the roles that have been assigned to you. Your role to abstract cases will be – **Facility Abstractor**. Click on the name, **Facility Abstractor**, to open up the options available to abstract cases.

Home	New Abstract	Find/Open Abstract	Held Abstracts	Reports	Change Password	Help	Log out
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Menu area of Web Plus contains the menu

This is the home page that contains the menu options. From this page you can access the main parts of Web Plus. Click on a tab to open that particular page.

Below is a table which describes the menu options on the home page.

Menu option	Description
Home	Opens the user's home page, which displays a list of links for the facilities and roles that have been assigned to you; to work on abstracts of a particular source, click on the link for the type of abstract
New Abstract	Opens the data entry page for a new abstract
Find/Open Abstract	Opens the page to search for existing abstracts
Release Abstracts	Opens the page that lists all abstracts that are ready for release
Reports	Opens the page that lists the reports available for viewing
Change Password	Opens the change password page
Help	About - Opens a page with the Web Plus, NAACCR, and Collaborative Staging Algorithm Version information
Log out	Logs the user out of Web Plus; opens Web Plus Log in page

Data Entry

To begin a new abstract, enter information for a patient, choose the **New Abstract** tab from the home page. The data entry page opens up.

Web Plus

Home

New Abstract

Find/Open Abstract

Held Abstracts

Reports

Change Password

Rasheda Hanvel
501-268-4129

Help

Log out

Enter new abstract

Add/View Comment

Run CS Edit

All data items marked with an asterisk (*) are required.

HOSPITAL SPECIFIC

Abstracted By

MR

Reporting Facility

000007100

Date Case Completed - CoC

Date Case Last Changed

Type of Reporting Source

4

Class of Case

12

Primary Payer

Date of 1st Contact

Date 1st Contact Flag

12

PATIENT DEMOGRAPHICS

Last Name

First Name

Middle Name

Edit Errors

Help

Enter an Abstract and click on Save at the bottom of the page to save it to the database. The abstract is edited each time you save. Edit errors, if there are any, will be shown in this message area. All your changes will be saved to the database even if there are edit errors.

Data entry Help Icons

Special Code Lookup

icon to the left of the data item links to a searchable listing of terms and coded values for the data item. When a specific code in the list is clicked, it is automatically filled into the abstract for the data item.

Calculate Field Value

icon to the left of a data item is clicked to automatically calculate the value for the data item from information that has been entered for other data items.

Context-Sensitive Help

icon to the right of each data item links to the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information regarding the coding of the data item.

Print Preview

Notice that the page has two main sections. The box on the left contains the fields where you enter your case information. The box on the right contains two tabs: Help and Edit Errors.

Edit Errors

Help

Enter an Abstract and click on Save at the bottom of the page to save it to the database. The abstract is edited each time you save. Edit errors, if there are any, will be shown in this message area. All your changes will be saved to the database even if there are edit errors.

Data entry Help Icons

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Context-Sensitive Help

icon to the right of each data item links to the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information regarding the coding of the data item.

Print Preview

This is the **Help** tab, it provides a legend describing the data entry help icons available to the abstractor and briefly describes the process of saving your abstract.

Entering Information into Fields

Enter new abstract

All data items marked with an asterisk (*) are required.

HOSPITAL SPECIFIC	
Abstracted By	MR
Reporting Facility	0000007100
Date Case Completed - CoC	
Date Case Last Changed	
Type of Reporting Source	4
Class of Case	12
Primary Payer	
Date of 1st Contact	
Date 1st Contact Flag	12

Date Flags: If date is left blank the reason must be recorded in the date flag field. If a date is entered then the flag field should be blank.

The fields you see depend on your facility and set up chosen by the ACCR administrator. The headings, such as Hospital Specific and Demographic, can vary. Your initials and reporting facility number will auto-populate. Do not worry about entering the Date Case Completed/Case Last Changed as these will be auto-populated as well.

Reporting source should be a **1** – for Hospitals (Use the drop-down box for options)

Class of Case depends on how the patient was diagnosed and/or treated at your facility. (Use drop down box)

- 00** – Diagnosed at facility only and treatment is known but performed elsewhere
- 10** – Diagnosed at facility and PART/ALL treatment or decision not to treat at facility
- 13** – Diagnosed at facility and PART treatment at the facility
- 14** – Diagnosed at facility and ALL treatment at the facility
- 20** – Diagnosed elsewhere and PART/ALL treatment at facility
- 21** – Diagnosed elsewhere and PART treatment at facility
- 22** – Diagnosed elsewhere and ALL treatment at facility

Primary Payer is the type of insurance patient has at diagnosis. (Use drop down boxes)

Date of 1st Contact – The date the patient was first seen at the facility for the cancer diagnosis. Date cannot be before the date patient was diagnosed.

EXAMPLE: Patient presents for chest x-ray on 1/1/2015 and found right lung mass. On 1/15/15 right lung biopsy performed reveal adenocarcinoma. Date 1st contact: 2015/01/01 (all dates entered YYYY/MO/DD)

PATIENT DEMOGRAPHICS		
Last Name	<input type="text"/>	
First Name	<input type="text"/>	
Middle Name	<input type="text"/>	
Maiden Name	<input type="text"/>	
SSN	<input type="text"/>	
Birth Date	<input type="text"/>	
Sex	<input type="text"/>	
Race	<input type="text"/>	
Race 2	99	
Race 3	99	
Race 4	99	
Race 5	99	
Spanish Origin	<input type="text"/>	
Addr Curr - Street	UNKNOWN	
Addr Curr - Supplemental	<input type="text"/>	
Addr Curr - City	UNKNOWN	
Addr Curr - State	ZZ	

If Race is coded to anything other than 99 (unknown), then Race 2-5 must be 88.

Complete the patient's demographic information based off the face sheet in the medical record or other appropriate source document. If unsure enter unknown (9's).

FOLLOW-UP/DEATH		
Date Last Contact	<input type="text"/>	
Date Last Cont Flag	12	
Vital Status	1	
Cause of Death	0000	
ICD Revision Number	0	
Death Place - Country	<input type="text"/>	
Death Place - State	<input type="text"/>	

Enter the last date the patient was seen at the reporting facility or known date of expiration.

CANCER IDENTIFICATION		
Sequence - Central	00	?
Date of Diagnosis		?
Age at Diagnosis		?
Primary Site		?
Text - Primary Site		?
Histology ICD-O-3	8000	?
Text - Histology		
Behavior ICD-O-3		
Grade	9	
Laterality		
Diagnostic Confirmation	9	
Addr at DX - Country	USA	
Addr at DX - Street		
Addr at DX - Supplemental		
Addr at DX - City		
Addr at DX - State	AR	
Addr at DX - Zip		
Addr at DX - County		?

Click on calculator button to get age;
Will only generate age when DOB and Date of Diagnosis is completed

Message from webpage

Clear and Re-code Collaborative Staging

Year of Date of Diagnosis is no longer between 2004 and 2015. Directly entered and derived Collaborative Staging values will be cleared.

Would you like to clear all these fields?

This message appears for any case that is diagnosed 2016 or later.

Click OK

OK Cancel

You will enter the information regarding the patient's cancer information in these areas.

Sequence Number: This is the number of cancers the patient has. If only one cancer leave it 00. However, if the patient has a history of another cancer unrelated to the current cancer enter the appropriate number.

EXAMPLE: Patient has a history of breast cancer in 2013. Patient presents now with endometrial cancer (1/1/2015) for a planned hysterectomy. The facility is reporting the 2015 endometrial case, the sequence number is 02.

Date of Diagnosis: The date the patient was diagnosed with cancer (YYYY/MO/DD)

Age at Diagnosis: Click the calculator icon to auto-populate

Primary Site: The site in which the cancer arose or began (Use ICD-O-3 book)

Histology: The morphology of the tumor (Use ICD-O-3 book)

Behavior: Only collect the in situ (/2) and invasive (/3) for most sites and benign (/0) or borderline (/1) for CNS sites. Please see reportable list for inclusion/exclusion lists.

Grade: The differentiation of the tumor. For solid tumors use codes 1-4 and 9. For lymphomas/leukemias use codes 5-8 and 9.

Laterality: Code the appropriate laterality for a paired site.

Diagnostic Confirmation: How the cancer was diagnosed. Listed below are the most common used.

- 1** – Positive histology (pathology report)
- 2** – Positive cytology (cytology report)
- 3** – Genetic tests + Positive histology (for lymphoma/leukemia only)
- 7** – Imaging (only found on scans)
- 8** – Clinical diagnosis- Physician statement (not any of the above)
- 9** – Unknown




Address at Diagnosis: The patient's address at the time of diagnosis

MPH/AMBIG TERMS 2007-2012	
Ambiguous Term	<input type="text"/>  
Date Conclusive DX	<input type="text"/> 
Date Conclusive DX Flag	<input type="text"/>  
Mult Tumors Rep as 1	<input type="text"/>  
Multiplicity Counter	<input type="text"/> 
Date Mult Tumors	<input type="text"/> 
Date Mult Tumors Flag	<input type="text"/>  




These fields are only to be used if the patient is diagnosed between the years 2007 and 2012. **They can be left blank.**

DIAGNOSTIC PROCEDURES




Text - Lab Tests

Any pertinent lab information: Breast: ER/PR/HER2 status Colon: CEA Prostate: PSA	 	
--	--	---




Text - PE

Age, race, reason patient was seen at the facility. Other pertinent physical exam information related to cancer. Family history, tobacco and alcohol use	 	
--	--	---




Text - Path

Collection date of pathology report, Pathology report number/accession number, synopsis of findings on pathology report	 	
---	--	---

Text - X-Ray/Scan

Date of scans, type of scans, Findings on scans (positive and negative) about cancer – spread of disease, involved lymph nodes, metastatic disease	 	
--	--	--

Text - DX Procedures - Op

Date of operative procedure, type of procedure and findings in operative note	 	
---	--	---

Text - DX Procedures - Scopes

<u>Procedures/Scopes:</u> Date of scope (colonoscopy, bronchoscopy, cystoscopy, etc.), Type of scope and findings in scope notes

Text Fields MUST be completed

If you don't have the information in your medical record, then enter 'unknown' for that particular field.

These are text areas where you will enter information as found in the medical record.

AJCC STAGING

Text - Staging

Enter any staging found in medical record as performed by a physician. Many times labeled as T, N, M and Stage Group, and sometimes it is just group stage: i.e. Stage 2B

Reg Nodes Positive	<input type="text" value="98"/>
Reg Nodes Examined	<input type="text" value="00"/>
Tumor Size Summ	<input type="text"/>
Mets Bone	<input type="text"/>
Mets Brain	<input type="text"/>
Mets Distant LN	<input type="text"/>
Mets Liver	<input type="text"/>
Mets Lung	<input type="text"/>
Mets Other	<input type="text"/>
Path TNM - T	<input type="text" value="X"/>
Path TNM - M	<input type="text" value="X"/>
Path TNM - M	<input type="text" value="X"/>
Path TNM - Stage Grp	<input type="text" value="99"/>
Path TNM - Descriptor	<input type="text" value="0"/>
Path TNM - Staged By	<input type="text" value="00"/>
Clin TNM - T	<input type="text" value="X"/>
Clin TNM - N	<input type="text" value="X"/>
Clin TNM - M	<input type="text" value="X"/>
Clin TNM - Stage Grp	<input type="text" value="99"/>

Record the largest size of the tumor from the pathology report. If there is no pathology report, then use the largest size from clinical findings. See FORDS 2016, e-p.159-161

2015 – leave blank

2016 – complete per FORDS 2016 guidelines

TNM is now updated to reflect TNM 7 edition.

2015 cases: Look up is not available

- You have to use the prefix 'c' or 'p' as applicable for the case – These must be lowercase
- The sub-category letters must be upper case. Example: Clin T code is c2A (not c2a)
- Remember the M must be c0 unless there is proven metastatic disease

2016 cases: Look ups are available

- Use TNM 7 manual to accurately code

If there is no surgery or pathologic classification not met make the pathologic T, N, M all blank – leave path stage group 99

Complete SEER Summary Stage

Reg Nodes Positive: The total number of regional lymph nodes that are positively involved on the pathology report

Reg Nodes Examined: The total number of regional lymph nodes that are pathologically reviewed

Path TNM T – The pathologic stage of the tumor

Path TNM N – The pathologic stage of the regional lymph nodes

Path TNM M – The pathologic stage of metastatic sites

Path TNM Stage Group – The pathologic stage group

Path TNM Staged By – The person who staged the case

Clin TNM T – The clinical stage of the tumor

Clin TNM N – The clinical stage of the regional lymph nodes

Clin TNM M – The clinical stage of metastatic sites

Clin TNM Stage Group – The clinical stage group

Clin TNM Staged By – The person who staged the case

TNM Edition - auto-populated field, don't change

SEER Summ Stg 2000 – SEER Summary staging for this case (Use drop down box)

COLLABORATIVE STAGING			
Lymph-Vasc Invasion		9	▼ ?
CS Tumor Size	🔍	999	?
CS Extension	🔍	999	?
CS Size/Ext Eval	🔍	9	?
CS Lymph Nodes	🔍	999	?
CS Reg Nodes Eval	🔍	9	?
CS Mets at DX	🔍	99	?
CS Mets at DX - Bone		9	▼ ?
CS Mets at DX - Brain		9	▼ ?
CS Mets at DX - Liver		9	▼ ?
CS Mets at DX - Lung		9	▼ ?
CS Mets at DX Eval	🔍	9	?
CS SSF1	🔍	999	?
CS SSF2	🔍	999	?
CS SSF3	🔍	999	?
CS SSF4	🔍	999	?
CS SSF5	🔍	999	?
CS SSF6	🔍	999	?
CS SSF7	🔍	988	?
CS SSF8	🔍	988	?
CS SSF9	🔍	988	?
CS SSF10	🔍	988	?
CS SSF11	🔍	988	?
CS SSF12	🔍	988	?

Collaborative Staging Items -

2015 & earlier cases – Complete all data items

2016 cases:

Leave the following data items blank:

- CS Tumor Size & Eval
- CS Lymph Nodes & Eval
- CS Mets @DX
- CS Mets
bone/brain/liver/lung
- CS Mets Eval

Complete the following:

- Lymph-vascular invasion (LVI)
- Required SSF

Lymph-Vasc Invasion: Record the lymphovascular invasion as found on the pathology report for the primary tumor. Use drop down box for codes.

CS Tumor Size: The size of the primary tumor in mm.

CS Extension: Record the furthest direct extension of tumor spread. Use magnifying glass for codes and notes.

CS Size/Ext Eval: Record where you located the tumor size and extension for the primary tumor (was it from scans, clinical, or from surgery, pathologic)

CS Lymph Nodes: Record whether or not regional lymph nodes are involved. Use appropriate codes.

CS LN Eval: Record where you located the involvement or lack of involvement for the regional lymph nodes (was it from scans, clinical, or from surgery, pathologic)

CS Mets at DX: Record whether or not metastatic disease was found at the time of diagnosis





































CS Mets – Bone – Refers to bone mets, use drop down box for codes

CS Mets – Brain – Refers to brain mets, use drop down box for codes

CS Mets – Liver – Refer to liver mets, use drop down box for codes

CS Mets – Lung – Refer to lung mets (not pleural mets), use drop down box for codes

CS SSF 1-25 – This varies by site, use magnifying glass for notes and codes

CS SSF25		<input type="text" value="988"/>	
Derived AJCC 6 T		<input type="text"/>	
Derived AJCC 6 T Desc		<input type="text"/>	
Derived AJCC 6 N		<input type="text"/>	
Derived AJCC 6 N Desc		<input type="text"/>	
Derived AJCC 6 M		<input type="text"/>	
Derived AJCC 6 M Desc		<input type="text"/>	
Derived AJCC 6 Stg Grp		<input type="text"/>	
Derived AJCC 7 T		<input type="text"/>	
Derived AJCC 7 T Desc		<input type="text"/>	
Derived AJCC 7 N		<input type="text"/>	
Derived AJCC 7 N Desc		<input type="text"/>	
Derived AJCC 7 M		<input type="text"/>	
Derived AJCC 7 M Desc		<input type="text"/>	
Derived AJCC 7 Stg Grp		<input type="text"/>	
Derived SS 1977		<input type="text"/>	
Derived SS 2000		<input type="text"/>	
CS Version Derived		<input type="text" value="020550"/>	
CS Version Current		<input type="text" value="020550"/>	

Click on the calculator button once you have completed the CS fields for 2015 and earlier cases; if you get an error make the correction and click the calculator button again; This will derive all the fields for CS

Once all data fields for CS are completed **click on the calculator icon** and it will derive the staging fields. If an error/edit comes up (it will not auto calculate, i.e. leaves blanks) fix the issue and hit the calculator icon again.

Treatment Information

TREATMENT - 1ST COURSE	
Date of 1st Course Rx - CoC	<input type="text"/>
Date of 1st Crs Rx Flag	10
Text - Surgery	
<div>Date of operation, Type of surgical procedure, any findings or information about surgery of primary site, lymph nodes, or metastatic sites</div>	
Surgery of Primary Site	99
Scope Reg LN Surgery	9
Other Reg/Dis Surgery	9
Surgical Margins	9
Reason No Surgery	9
Date of Surgery	<input type="text"/>
Date of Surgery Flag	10
Date Most Defin Surgery	<input type="text"/>
Date Most Defin Surg Flag	10
Date Surgical Discharge	<input type="text"/>
Date Surgical Disch Flag	10
DX/Staging Procedures	09
Date DX/Staging Proc	<input type="text"/>
Date DX/Staging Proc Flag	10

The earliest treatment

Date Flags: If date is left blank the reason must be recorded in the date flag field. If a date is entered then the flag field should be blank.

This area records the treatment that the patient received either at your facility or another facility. Please record any known treatment that the patient received. The first section is on **Surgical Procedures**.

Date of 1st Course RX: Record the date on which treatment began at any facility. If the patient receives active surveillance or watchful waiting as part of first course treatment, then the date this decision was made is entered here (Treatment Status = 2). In case of non-treatment, either based on physician, patient, or family decision not to treat, then enter the date this decision was made (Treatment Status = 0). Enter dates YYYY/MM/DD.

Surgery Primary Site: Type of surgery performed to the primary site. Use the question mark to get a list of codes and notes.

Scope Reg LN Surgery: Record any procedure performed to regional lymph nodes in this area. If there is a biopsy, excision, or FNA performed to the regional lymph nodes record that information even if there is no surgery to the primary site. Use drop down box for codes.

Other Reg/Dist Surgery: Record surgery performed to regional organs and/or distant sites (metastatic sites) for the purpose of cancer treatment. Use drop down box.

Surgical Margins: Record whether or not margins are negative (no cancer in margins) or positive (cancer in margins). Macroscopic: seen by surgeon during operation, known that cancer was left behind. Microscopic: only seen by microscope during pathologic review of tissue.

Reason No Surgery: If there is no primary site surgery then record the reason here. Use drop down boxes for codes.

- 0 – Surgery performed
- 1 – Surgery was not planned
- 2 – Surgery was not recommended due to patient co-morbidities/risk factors
- 5 – Patient expired prior to surgery being performed
- 6 – Surgery recommended, but not performed and no reason noted in patient record
- 7 – Patient or patient's family refused surgery
- 8 – Surgery recommended but unknown if it was performed. Follow-up recommended
- 9 – Unknown if surgery recommended or performed

Date of Surgery: Record the date of the first surgery performed, even if it is biopsy of lymph node prior to primary site surgery.

Date Most Definitive Surgery: Record the date of the most definitive, or the operation that removed the majority of the primary site.

Example: A breast cancer patient undergoes a lumpectomy/excisional biopsy on 2/1/15 and then has a partial mastectomy on 3/1/15.

Date of surgery: 2015/02/01

Date Most Definitive Surgery: 2015/03/01

Date Surgical Discharge: Record the date the patient was discharged following the most definitive surgery.

DX/Staging Procedure: Code the incisional biopsy of the primary site or other sites that was used to diagnose and/or stage the case. Do **not** record FNA or other cytologic studies in this field. Use drop down box for codes.

These are the common codes:

- 00 – Biopsy was not performed
- 01 – A biopsy was done to a site other than the primary

- 02** – A biopsy was performed to the **primary site**; for lymphoma cases a biopsy of a lymph node to stage lymphoma was performed
- 03** – Surgical exploration **WITHOUT** biopsy or treatment
- 09** – No information on diagnostic or staging procedure

DX/Staging Procedure Date: Record the date of the biopsy performed as coded in DX/Staging Procedure.

Radiation Treatment

Text - Radiation (Beam)

Date Radiation began and ended, site that received radiation, type of radiation, number of fractions, dosage.

Text - Radiation Other

Date Radiation began/ended. Brachytherapy information entered into this text field.

Rad - Regional RX Modality	99	▼	?
Rad - Regional Dose cGy	99999		?
Rad - Boost RX Modality	99	▼	?
Rad - Boost Dose cGy	99999		?
Rad - No of Treatments	999		?
Rad - Treatment Volume	99	▼	?
Rad - Location of RX	9	▼	?
Surgery/Rad Sequence	0	▼	?
Reason No Rad	9	▼	?
Date Rad Started			?
Date Rad Started Flag	10	▼	?
Date Rad Ended			?
Date Rad Ended Flag	10	▼	?

The best source of information to complete radiation treatment will be found on the radiation oncologist's summary letter. Please complete the information to the best of your availability. Frequently radiation is delivered in two or more phases which can be summarized as "regional", which is usually the larger dose/field, and "boost", which is generally smaller dose.

Regional RX Modality: Record the type of radiation performed as part of the regional treatment. If IMRT or 3D conformal is mentioned code these as such.

Example: Patient received 15mv photons, using IMRT for prostate cancer.

Regional RX Modality: 31

Regional RX Dose: Record the dose as indicated by the radiation oncologist's summary letter which is usually in the form of cGy. Do not include boost dosage if one was given.

Example: A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000cGy followed by boost to 7,000cGy. **Regional dose** coded as **05000**.

Photon Treatment: reported as cGe, record regional dose in cGy: 100xcGe.

Example: photon treatment, 50cGe, administered. **Regional dose:** 05000

Brachytherapy/Radioisotopes: Code regional dose as **88888**

No radiation administered: Code as **00000**

Unknown if radiation administered: Code as **99999**

Boost RX Modality: Record the type of radiation performed as part of the boost treatment. If IMRT or 3D conformal is mentioned code these as such.

Boost RX Dose: Record the dose as indicated by the radiation oncologist's summary letter which is usually in the form of cGy. Do not include regional dose.

Example: A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000cGy followed by boost to 7,000cGy. **Boost dose** coded as **02000** [Total (7,000cGy) – Regional (5,000cGy) = Boost (2,000cGy)]

Photon Treatment: reported as cGe, record boost dose in cGy: 100xcGe.

Brachytherapy/Radioisotopes: Code regional dose as **88888**

No radiation administered: Code as **00000**

Unknown if radiation administered: Code as **99999**

Rad No of Treatments: Total number of treatment sessions (fractions) administered during first course treatment. This is typically found in the radiation summary letter.

000 – None

001-998 – Actual number of treatment (fractions)

Example: Patient with breast carcinoma had radiation administered to chest wall and separately to ipsilateral supraclavicular region for a total of three treatment portals. Twenty-five fractions were given. Record **025**

999 - Unknown

Rad Treatment Volume: Identifies the anatomic target of the most clinically significant radiation therapy delivered to the patient. Typically this will be found on the radiation summary letter. If two volumes are targeted and one of those includes the primary site, record the treatment to the primary site. Use drop down box for codes.

Rad Location RX: Record the location/facility where the radiation was administered.

Surgery/Rad Sequence: Records the sequence of radiation and surgical procedures given as part of first course treatment. If patient received both radiation and any one (or more) of the following surgical procedures: *Surgery Primary Site*, *Regional Lymph Node Surgery*, or *Surgery Other/Distant sites* then **code this item 2-9** as appropriate. Use drop down box for codes.

Reason No Rad: Records the reason no regional radiation therapy was administered. Use drop down box for codes.

Date Rad Started: Enter the date radiation began

Date Rad Ended: Enter the date radiation ended

Systemic Treatment

If unsure that a drug is used to treat cancer or unknown type use SEER RX* to help you,

<https://seer.cancer.gov/seertools/seerrx/>

Text - Chemotherapy

Enter date chemotherapy began,
Chemotherapy drugs administered, physician
name

Chemotherapy 99

Date Chemotherapy Date Chemo began

Date Chemo Flag 10

Enter chemotherapy:

- 00 – None
- 01 – Chemo, NOS
- 02 – Single drug
- 03 – Multiple drugs
- 88 – Recommended, unknown if began
- 99 – Unknown

Text - Hormone Therapy

Enter date hormone therapy began, type of
hormone therapy and physician name

Hormone Therapy 99

Date Hormone Therapy

Date Hormone Flag 10

Enter Hormone Treatment:

- 00 – None
- 01 – Hormone administered
- 82 – Not given because contraindicated
- 88 – Recommended, unknown if began
- 99 – Unknown

Text - Immunotherapy

Enter date that BRM/Immunotherapy began,
type of drugs administered, and physician name

Immunotherapy 99

Date Immunotherapy

Date BRM Flag 10

Enter Immunotherapy Treatment:

- 00 – None
- 01 – Immunotherapy administered
- 82 – Not given because contraindicated
- 88 – Recommended, unknown if began
- 99 – Unknown

Other Therapy	9	?
Date Other Therapy		?
Date Other Flag	11	?
Transplant/Endocrine	99	?
Date Systemic	Date systemic TX began	?
Date Systemic Flag	10	?
Surgery/Systemic Seq	0	?
Treatment Status	9	?

Other Treatment:

- 0 – None
- 1 – Other (not assigned to specific treatment)
- 2 – Experimental (clinical trial-institution)
- 3 – Double Blind trial
- 6 – Unproven administer by nonmedical personnel
- 9 – Unknown

Transplant/Endocrine:

- 00 – None
- 10 – Bone Marrow transplant
- 30 – Endocrine surgery/radiation TX
- Example: Bilateral orchiectomy for prostate cancer patient to decrease hormone levels in the body, and treat cancer
- 99 - Unknown

OTHER

Text - Remarks

Record any other information pertinent to the cancer that was not addressed in any other fields, i.e. Referral to another facility/physician

Record whether any treatment was administered or under active surveillance.

Treatment Status:

- 0 – None
- 1 – Treatment given
- 2 – Active Surveillance/Watchful waiting
- 9 - Unknown

Once you have completed the case click on **SAVE**. A message will appear letting you know if the case passed edits. Once edits are passed click on the **YES** button to release the case to ACCR.

Edit Errors	Help
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-----EDIT RESULT-----



















































Editset Name: ACCR V14 Edits - CCOREv2

This abstract passed all edits.
Do you want to release it?

Yes No

Edit Over-Rides

If you have an edit when you click the save button there may be a message asking you to over-ride the edit. If the information you entered is correct, and you are given the option you can over-ride that particular edit here in these fields. Please leave these blank if you have no over-ride edits or are unsure. Please contact someone at ACCR for assistance.

OVER-RIDES/CONVERSION/SYSTEM ADMIN.		
ORide Acsn/Class/Seq	<input type="text"/>	 
ORide Age/Site/Morph	<input type="text"/>	 
ORide Site/Type	<input type="text"/>	 
ORide Histology	<input type="text"/>	 
ORide HospSeq/DxConf	<input type="text"/>	 
ORide HospSeq/Site	<input type="text"/>	 
ORide Ill-Defined Site	<input type="text"/>	 
ORide Leuk/Lymphoma	<input type="text"/>	 
ORide Report Source	<input type="text"/>	 
ORide SeqNo/DxConf	<input type="text"/>	 
ORide Site/Behavior	<input type="text"/>	 
ORide Site/EOD/DX Date	<input type="text"/>	 
ORide Site/Lat/EOD	<input type="text"/>	 
ORide Site/Lat/Morph	<input type="text"/>	 
ORide Site/Lat/SeqNo	<input type="text"/>	 
ORide Site/TNM Stg Grp	<input type="text"/>	 
ORide Site/Type	<input type="text"/>	 
ORide SS/NodesPos	<input type="text"/>	 
ORide SS/TNM-M	<input type="text"/>	 
ORide SS/TNM-M	<input type="text"/>	 
ORide Surg/DxConf	<input type="text"/>	 
ORide CS 1	<input type="text"/>	 
ORide CS 2	<input type="text"/>	 
ORide CS 3	<input type="text"/>	 
ORide CS 4	<input type="text"/>	 
ORide CS 5	<input type="text"/>	